MEDICAL ASSISTANCE ADMINISTRATION
QUALITY UTILIZATION SECTION (QUS)
PO BOX 45506
OLYMPIA WA 98504-5506

(1) WHEELCHAIR PURCHASE EVALUATION
(for home clients only)

NOTE: The small numbers coordinate with the instructions. **Do not alter this form in any way.**
(2) **All spaces MUST be completed within 60 days of request including signature of person completing the section and date completed.**

(2) SECTION 1 - The vendor may complete information in this section.			
CLIENT NAME		CLIENT PIC	(3) RX ON FILE? ☐ Yes ☐ No
NURSING FACILITY (IF APPLICABLE)			
PHYSICIAN/THERAPIST NAME			FAX NUMBER
(4) LOWER LEG LENGTH (INCHES)	(4) UPPER LEG LENGTH (INCHES)	(4) HIP WIDTH MEASUREMENT (INCHES)	
DOES CLIENT CURRENTLY OWN A WHEELCHAIR? ☐ Yes ☐ No	IF YES, ☐ Manual ☐ Power	PURCHASED BY ☐ Private ☐ DSHS ☐ Donated	DATE PURCHASED
APPROXIMATE AGE	MAKE	MODEL NUMBER	SERIAL NUMBER
PHYSICIAN, THERAPIST OR VENDOR SIGNATURE			DATE

(2) SECTION 2 - This section may only be completed by the physician or therapist.

(5) Diagnosis/Specific /Disabilities as applies to requested equipment including relevant degree of contractures.

(6) INDICATE IF APPLICABLE ☐ Scoliosis ☐ Kyphosis Degree of curvature_____	PATIENT HEIGHT (INCHES)	PATIENT WEIGHT (LBS.)

	Yes	No
Will equipment be needed approximately six months or less?	☐	☐
Will the requested equipment meet the client's long term needs?	☐	☐

If no, please explain:

_____

_____

_____

_____

Will the client use the wheelchair everyday?	☐	☐

If yes, how many hours per day? _____

If no, please explain:

_____

_____

_____

_____

What is the client's ambulation status and limitations? (Please describe, including: weight bearing, mobility aids and distance)

	Yes	No
If manual wheelchair, can client effectively and independently propel the wheelchair?	☐	☐

If yes, number of feet propelled at one time in the requested wheelchair: _____

Does client propel with: ☐ arms ☐ feet ☐ both

If power wheelchair, can client safely and independently utilize/drive the chair?	☐	☐

If yes, distance in feet at one time: _____

Indicate client specific medical justification for each of the following: (Photos and or videos are helpful)

Recommendations: If you are unsure of the client's specific wheelchair needs, including make/model of wheelchair and all accessories and modifications, refer the client to a physical/occupational therapist for a complete wheelchair evaluation.

(7) MAKE AND MODEL OF EQUIPMENT

(7 A-F) All Accessories and Modifications: (You may submit additional attachments)

(8) If the client's current wheelchair does not meet the medical need, why not?

(2) PHYSICIAN'S SIGNATURE	DATE
(2) THERAPIST'S SIGNATURE	DATE

INSTRUCTIONS

1. This form is for all MAA clients requiring a wheelchair purchased for their use.
2. All spaces must be completed, signed and dated within 60 days of MAA receiving request. Form has been split into two sections. Section 1 may be completed by the vendor or can be completed by the doctor or therapist. Section 2 may only be completed by the doctor or therapist.
3. RX on file means: The vendor must have a physician's prescription in the client's file for any new equipment or new accessories on existing equipment due to a change in medical condition. If the client resides in a nursing facility, they too must have a copy of the physician's prescription on file.
4. Please indicate all measurements in inches. Lower leg length is measured from the popliteal crease to base of heel. Upper leg length is measured from back of buttocks to popliteal crease. Hip measurement is measured from hip tissue to hip tissue.
5. Only list those diagnoses and disabilities that apply to the equipment being requested.
6. If a custom back or wheelchair with tilt in space or recline feature is being requested, the information regarding scoliosis and kphosis must be completed.
7. The make/model of wheelchair and each accessory/modification requested must be justified separately. You may use the lines on the physical therapy evaluation form or you may submit an additional attachment listing each item and the medical necessity for them.

   When justifying the equipment and accessories the following information is necessary.

   A. Indicate what other less expensive alternatives have been tried or considered and why they will not meet the client's medical needs.
   B. All justifications must be client specific. General statements as to standards of care or industrial standards for generalized equipment use are not appropriate to justify specific equipment needs.
   C. When requesting a specialized back or a wheelchair with a tilt in space or recline feature, indicate the degree of curvature requiring the modification (e.g. scoliosis, kyphosis or lordosis).
   D. Indicate if the client has excessive extensor tone/muscle spasticity of the trunk/upper body muscles re quiring support or impacting the degree of hip flexion/extension.
   E. For specialized cushions, indicate what other cushions have been tried, what the documented outcome was and the length of trial or what other cushions were considered and why they will not meet the client's medical needs. Also document if client has an existing decubitus and if so what the stage is. If the client has a history of decubitus, indicate dates, stage, site and duration.
   F. Indicate if the client has any musculoskeletal conditions, cast or brace that prevents 90-degree flexion of the knee or hip.
8. If client already owns a wheelchair, and a new wheelchair is being requested, indicate the medical reasons the existing wheelchair no longer meets the client's needs. Indicate if it can be repaired or modified to meet the client's needs and if not, why not. If the chair can be repaired or modified to meet the client's needs, the vendor supplying the equipment will need to submit a cost comparison for repairs vs. purchase.